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ABSTRACT

This booklet contains excerpted remarks by government and public health officials concerning social marketing and its use. It is noted that the agencies they represent are among those that are considered pioneers in applying social marketing to some of the toughest problems facing America. Topics concerning government, public health, and the use of social marketing include such areas as Acquired Immune Deficiency Syndrome (AIDS), cholesterol control, drunk driving, and drug abuse. General discussions on marketing concepts and their use in public health education are also explored. A foreword by William A. Smith of the Academy for Education Development identifies critical concepts of social marketing including the concept of exchange, the marketing mix, and the importance of audience research. Speakers are Terry Bellicha of the National Heart, Lung, and Blood Institute; Avrahan Forman of the National Institute of Drug Abuse; Nancy Pielemeier of the U.S. Agency for International Development; Beverly Schwartz of the Centers for Disease Control; and Sharyn Mallamad Sutton of the National Cancer Institute. An Afterword entitled "Social Marketing in a Changing World: A Private Sector Perspective" by Porter/Novelli, a social marketing firm, concludes the booklet. (GLR)

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Social Marketing

Views from Inside the Government

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AED
ACADEMY FOR EDUCATIONAL DEVELOPMENT

The Academy for Educational Development (AED) is an independent, nonprofit organization that addresses human development needs through education, communication, and information. Under grants and contracts, AED operates programs for government and international agencies, educational institutions, foundations, and corporations. Since its founding in 1961, AED has conducted projects throughout the United States and in more than 100 countries in the developing world.

In partnership with its clients, AED seeks to increase access to learning, transfer skills and technology, and support institutional development.

30TH ANNIVERSARY SEMINAR SERIES

Social Marketing

Views from Inside the Government

Foreword:

William A. Smith

Panelists:

Theresa Bellicha
Avrahan Forman
Nancy Pielemeier
Beverly Schwartz
Sharyn M. Sutton

Afterword:

Porter/Novelli

October 1991

These remarks are extracted from presentations made at a panel discussion held at AED on June 5, 1991 as part of its 30th Anniversary celebration.

AED

ACADEMY FOR EDUCATIONAL DEVELOPMENT

Foreword

William A. Smith

Academy for Educational Development

William A. Smith is Executive Vice President at the Academy and Director of the Social Development Programs. Dr. Smith came to social marketing as a practical solution to organizing communication programs for infant health. Since 1978, he has helped to adapt social marketing to the behavior change needs of AIDS, STDs, family planning, maternal child nutrition, environment, and family practices. Perhaps his most interesting contribution has been the incorporation of formal behavior change theory to the pragmatic approach of classical social marketing. Dr. Smith has an Ed.D. in nonformal education from the University of Massachusetts.

Why don't people do what's good for them? Why don't they stop smoking, eat right, stick to one faithful sexual partner, or at least use a condom when they don't? Why don't people get their kids immunized and why do teenagers keep trying dangerous drugs and ruining their lives?

The search for an answer to these questions about changing people's behavior has led several government agencies to explore social marketing. The logic of this exploration was expressed first in 1971 when someone asked, "Why can't we sell good health the way we sell toothpaste?" After two decades of trying, we know that drug abuse and condom use and smoking cessation don't sell as easily as toothpaste, but we also know that the principles of social marketing can lead to improved programs of public health.

Philip Kotler, one of social marketing's founding fathers, provided a simple and sensible definition of social marketing. "It is the design, implementation, and control of programs aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters." The definition emphasizes several important points about social marketing. First, it is a

program design and implementation **process**. It is not a theory or an idea — it is a process for organizing interventions. Secondly, social marketing works for **ideas** like "stop smoking," "don't use drugs," "stick to one faithful sexual partner," as well as it does for **practices and products** like condoms, immunizations, and regular breast examination for cancer screening. Finally, social marketing focuses not on everybody, but on **target adopters** — a specific subset of a population chosen because it is at particular risk and because its members share important values that make it possible to address appeals to them that work for the entire subgroup.

Among the most important ideas that social marketing has contributed to our thinking have been:

1) **The Concept of Exchange**. Behind marketing is the notion that people do new things or give up old things "**in exchange for**" benefits they hope to receive. Unless we identify a benefit people actually want — a benefit we can offer "in exchange for" what we want from them marketing argues that people are not likely to take our advice. The challenging, and yes also disturbing, reality is that the "benefits" people want often have little or nothing to do with the health benefits we want them to care about.

We want teenagers to drive without drinking because the "benefit" we want them to experience is avoiding death. But we know that many teenagers see

Most public health managers don't usually think of doctors, nurses, family members, or friends as a sales force — but they are.

death as a distant probability. Avoiding death is not perceived by them as a benefit, no matter how dramatic we make a TV spot on death, drinking, and driving. But some teenagers do fear disfigurement — being scarred for life — no cute face...no dating...no friends! "To avoid disfigurement" is a benefit some teenagers can believe in. The search for what to give people "in exchange for" what we want is at the very heart of successful social marketing.

2) **The Marketing Mix**. Social marketing is also practical. It offers four basic categories of inputs that program managers can organize and shape to give people what they want. Marketers, social or commercial, call these categories the four Ps. Shaping the four Ps is called developing the marketing mix.

The first thing managers can shape is the **product** "P." For example, they can make condoms more attractive by adding lubricants or making them stronger, thinner, colored, ribbed, or smooth. They can also shape an immunization service by making it more convenient, more fun, and less time-consuming. **Price** is the second "P" managers can shape. This is a complex cluster when talking about social ideas but one which leads us to discover the real barriers people experience in trying a new health behavior. The manager's job is to reduce the cost or barriers people face. **Place** is the third "P." It includes the distribution system and sales force. Most public health managers don't usually think of doctors, nurses, family members, or friends as a sales force — but they are. And marketing gives managers a powerful set of tools to help health professionals, peers, and the family become better salespeople. It helps them become more understanding, more articulate, better listeners, and more sensitive to their audience's needs. Finally, there's the **promotion** "P." This, of course, is what most people believe social marketing is all about TV spots, slogans, celebrity spokespeople, etc. It is not what social marketing is about! It is an important program element but it is only one element. Promotion is the voice of the

program. It deals with messages and channels: what to say and how to get it heard. And again, social marketing has brought life and new thinking to the business of effective and persuasive communication.

The most important insight of social marketing is the interrelation of the four "Ps"; the balancing act that program managers must go through to choose the most important of the four inputs to shape for the product and the audience. For condom use, managers may not have to worry about place or price — the real problem may be product design and promotion. For breast self-examination, a manager might find the real issue to be the barriers women experience in facing up to the possibility of cancer. The point is, the mix — the importance of each "P" — varies from one problem and one audience to another.

3) **Audience Research**. Social marketing is built around a sequence of program development that says assess then plan; pretest then implement; monitor and evaluate, and then re-plan. The intermingling of action and research is absolutely fundamental to successful marketing. The audience is the center of this intermingling. Marketing has given us not only an appreciation for audience research but numerous tools — from intercept surveys, to focus groups and ethnographies that bring qualitative and quantitative techniques together to build a better picture of the audience, their needs, and the benefits they desire. No other program design system places more emphasis on practical field research to guide program decision than social marketing.

Social marketing is a practical way to integrate service delivery with what we at the Academy believe is a fundamental counterpoint to service delivery, consumer demand. People must want to use new services. They must know how to use those services easily and then must be able to seek them out effectively. Social marketing gives us a way to increase consumer demand

and improve service delivery by using a single and systematic framework. But social marketing is still often misunderstood — maligned as being superficial or even unethical. It is still, too often, on the defensive in the public health community.

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I'm very pleased to introduce a small cadre of top professionals working within government and public health who understand and have incorporated social marketing in their own ways in their own agencies. The agencies represented here today are among the pioneers in applying social marketing to some of the toughest problems facing America. Our speakers are not here representing their agencies. They speak for themselves and yet they bring with them years of experience in government and public service. I'm particularly excited to have them tell their stories as they have lived them: being on the inside of government looking out at the world of social marketing.

Terry Bellicha

National Heart, Lung, and Blood Institute

Terry Bellicha joined the National Heart, Lung, and Blood Institute as the Chief of Communications Marketing and Public Information in the Office of Prevention, Education, and Control, in 1982. She directs the communications and public affairs activities of the Institute and its various education programs: high blood pressure, cholesterol, smoking, asthma, and heart attack alert. She has been a Project Manager for the Healthy Mothers and Health Baby program for the U.S. Public Health Service. And she has more than 20 years experience in health communications and public affairs and in marketing health and health education.

I'm pleased to be here representing one of the longer-running social marketing shows in town. The National Heart, Lung, and Blood Institute (NHLBI) has been carrying out social marketing for public health since it started the National High Blood Pressure Education Program. That was just about 20 years ago. While high blood pressure education was one of the early examples of social marketing in the government, it was not articulated as such. Widescale education and control of high blood pressure to reduce the risk of stroke and heart disease became public health goals back in the early 1970s, at just about the same time that Philip Kotler and his colleagues were starting to define the art and science of social marketing. So, while the program didn't give itself the social marketing label until much later it was still social marketing by another name. It had all the hallmarks.

From the beginning, the program took a comprehensive approach. It formed partnerships with medical and voluntary organizations, and it integrated mass media, community outreach, and professional education. And it took a decidedly consumer- oriented approach, even from the beginning. Using marketing research, target audiences were identified and segmented, barriers and opportunities for change were identified,

and messages were tested and refined over time. This was all early in the program, but in those days, as today, the program was monitored and it has changed. It has changed as the science has evolved and as the target audience, health care delivery, and clinical practice have changed. For example, when the program started only about 29 percent of the public knew of the relationship between high blood pressure and stroke and only about 24 percent could tell you that high blood pressure causes heart disease. Furthermore, only about half of all hypertensives were aware that they had the condition. As awareness began to increase and detection became more widespread, the audience and then the campaign messages changed.

From the beginning, the program took a comprehensive approach. It formed partnerships with medical and voluntary organizations, and it integrated mass media, community outreach, and professional education.

In about a decade, considerable advances were made. By 1985, 91 percent of the public knew that high blood pressure increases one's chance of getting heart disease, 77 percent could tell you that it was likely to increase your chance of stroke, and almost 75 percent of hypertensives were aware that they had the condition.

In the wake of these changes, the audience was refined and segmented. Today we aim messages at aware hypertensives,

those people who know they have the problem. The African-American population gets special attention also, because of the high prevalence of high blood pressure and stroke in that group.

And the messages have changed. In the beginning, we focused on awareness and detection. Then, the message shifted to an emphasis on demonstration of treatment skills. We recited a litany of treatment behaviors: over and over we told people, "Watch your weight." "Cut the salt." and "Take your pills." Today, people can still recite those messages. Today's campaigns are aimed at motivating hypertensives to stay with their treatment. And, we use social marketing tools to help us refine that message and deliver it more effectively.

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We think that the National High Blood Pressure Education Program reflects a long-term commitment to public health. When we talk about changes in behavior and health status in this area, we are talking about generational change. That change has been impressive.

Since 1972 when the program began, detection, awareness, knowledge, and treatment all have increased dramatically. Most people who have high blood pressure today know it. About 85 percent of people are aware of their condition, and about 95 percent of the population (just about everyone) has had a blood pressure reading in the last two years. Physician visits for high

blood pressure have increased almost 70 percent, whereas visits for other causes have remained relatively stable. But the best story is about the reduction in mortality from stroke. Since 1972, the age-adjusted stroke mortality rate has declined by more than 50 percent, and that's the figure the program is the proudest of.

Here there is a federal program that falls within the framework of social marketing; has been around a pretty long time; and has enjoyed substantial success. What are the implications of that for other social marketing programs in the federal sector? What do we think lies ahead? The National High Blood Pressure Education Program is much valued within my agency, and it should be. It's widely recognized as a model by other public health agencies and by health-related agencies in the private sector. In fact, we're not shy about applying the lessons that we've learned from high blood pressure to ourselves. The high blood pressure program has served as a role model for the other educational programs that NHLBI now runs. Those include the National Cholesterol Education Program, the National Asthma Education Program, the National Blood Resource Education Program, and the National Heart Attack Alert Program. Other federal agencies have also used the high blood pressure program as a model for their own efforts. A recent example is the National Eye Health Education Program, which is being implemented by the National Eye Institute, one of our sister institutes at NIH.

Our program expansion efforts have not been painless. Admittedly it has been difficult to support each program with the depth of funding and staff resources that high blood pressure has enjoyed over the years. The program pie is only so large and we keep slicing it thinner and thinner.

It's also generally true (and I imagine my colleagues are going to say this too) that social marketing is not widely recognized as a discipline within the federal bureaucracy — certainly

not the parts that I am familiar with. That's particularly true in the upper management levels. It is just not articulated as such, even though we practice it. I think the role of social marketing, its benefits, its application in the federal setting, all need to be better articulated. And, I think a good understanding of social marketing will help make a case for preserving the comprehensive health education programming that's so important to what we're trying to accomplish. I also believe this will help us ensure that we learn from our successes and our failures.

As for the challenges that might lie ahead, certainly one of the greatest is the need to develop strategies for minority populations, for the underserved, for the disadvantaged, for the people who bear the burden of disease — a disproportionate burden — and who have less access to medical care.

In my agency this is true in all of our program areas. In cardiovascular disease, as I mentioned, hypertension is more prevalent in the African-American population: about 38 percent versus 29 percent in the white population. Cardiovascular disease is also more severe and more likely to develop at an earlier age in African-Americans, and they're more likely to die from stroke.

In lung disease, asthma deaths are three times greater in the African-American population than in the white population, and the gap is continuing to widen. That's alarming. In blood diseases, African-Americans, Hispanics, and other minorities who have leukemia or other blood diseases that require bone marrow transplants have much less chance of finding a match than white people. There simply are not enough minorities yet on the National Marrow Donor Program's registry.

Another challenge is that health communications issues seem to be getting more and more difficult and complex. Maybe we've done the easy things. We've taught people how to take care

of high blood pressure — they can recite it to you. But now we have to keep them motivated to follow a lifetime of treatment that often requires substantial lifestyle change. In education about cholesterol, a cornerstone of our program is what we call the population strategy. It's nothing less than changing the eating habits of everyone over the age of two to lower the average blood cholesterol level in the population and thus reduce the risk of heart disease. And, we must accomplish this in a marketing environment filled with contradictory messages. There are "no-cholesterol" labels on products that never had any cholesterol to begin with. There are conflicting claims for fish oil and oat bran, and my favorite is the new ad for Wendy's suggesting that when you've got to have one it should be a quarter-pound burger topped with cheese and three strips of bacon and covered with cheese sauce.

In bone marrow donation, we have to reach minority populations who don't even have a tradition of blood donation which is often a gateway to bone marrow donation, and who might have significant cultural barriers to donation.

As for the challenges that might lie ahead, certainly one of the greatest is the need to develop strategies for minority populations, for the underserved, for the disadvantaged, for the people who bear the burden of disease — a disproportionate burden — and who have less access to medical care.

We're striving to meet these challenges through our patient, public, and professional education programs and through our partnerships with other medical organizations, state health departments, and so on. We depend on the tools of social marketing to help us. But I think there's much to do and much to learn from the national and international efforts of AED, for example, from my colleagues on the panel, from our own homegrown successes and failures.

We even have something to learn, I think, from very ancient sources. I brought along a sample of one of our radio campaigns on cholesterol because I think it illustrates our social marketing repertoire much more entertainingly than I can do. I think many of you are probably familiar with the comedians Mel Brooks and Carl Reiner. Back in the sixties, they did a series of sketches called the "Two Thousand Year Old Man." They haven't performed it since, but we asked them to resurrect the "Two Thousand Year Old Man" and do a radio campaign to educate the public about cholesterol. To give you an idea of their humor, I'd like first like to play for you a short sketch of the original "Two Thousand Year Old Man." This was recorded at the Cannes Film Festival.

REINER: I'd like you to meet now a gentlemen who I've had the pleasure of meeting and interviewing two or three times before, The Two Thousand Year Old Man.

BROOKS: Hello there, how are you, good to see you.

REINER: You know many people still do not believe that you are 2,000 years old, but it has been authenticated, you are that.

BROOKS: Yes I certainly am. I have a birth certificate in the land of Og, but I don't carry my birth certificate around.

REINER: Why?

BROOKS: Because it's a boulder, it's inscribed on a hard stone.

REINER: It would be cumbersome.

BROOKS: You can't carry it. Credit cards — that's a novelty.

REINER: Sir, are there any more secrets you're ready to divulge about why and how to live 2,000 years?

BROOKS: Well, one of the big things that's kept me rolling along, singing that song, is garlic.

BELLICHA: This is medical.

REINER: Garlic has kept you alive?

BROOKS: Yes.

REINER: How can garlic keep you alive?

BROOKS: Well, it keeps you alive because, well, you know how you die, don't you? The scientific reason how you die is that the Angel of Death, see, rings your apartment bell, and you let him in, and bang, you know he comes in and says, "Okay Murray, this is it, and --"

REINER: So how does garlic help?

BROOKS: Usually comes at night, right? So before I retire, I'll eat myself a nice pound and a half garlic, then I lay down in bed and I pull up my old crazy quilt, and I'll start in to *retire and snore.*

REINER: And how does the garlic help?

BROOKS: Well, the Angel of Death, you know, comes in, he comes over to me, taps me on the shoulder, I say, " Who is this?" and usually he goes, " Whoop," I shut the door, and that's it.

REINER: Well, that's an interesting theory.

BROOKS: Sure, you know about the kiss of death right? Surely he's not going to kiss me, I'm full of garlic.

REINER: I see.

It pays to pay attention to the survivors.

MS. BELLICHA: That's what the humor is like in the "Two Thousand Year Old Man." And with that in mind, I'd like to play for you the radio PSA that we did. Here is the Two Thousand Year Old Man talking to you from a remote cave about cholesterol.

REINER: We're in a remote cave to interview the man who claims to be 2,000 years old. Tell me sir, if you really are 2,000 years old, what is the secret of your longevity?

BROOKS: Fear.

REINER: Fear?

BROOKS: Fear of dying. I won't do anything that makes me die.

REINER: You take care of yourself then. I assume you watch your cholesterol?

BROOKS: Day and night, night and day, you are on the one. I always watch my cholesterol, I had it checked by the doctor who invented cholesterol.

REINER: Who is that?

BROOKS: Bernie, he had his office in the next cave. Dr. Bernie, the cholesterol doctor.

REINER: And was your cholesterol high?

BROOKS: How high is the moon? I had to give up dinosaur meat altogether.

REINER: You gave it up cold turkey?
BROOKS: No, I ate cold turkey, but not the skin.
REINER: Well, obviously whatever you did is working. You're in great shape for someone who's 2,000 years old.
BROOKS: I'm in great shape for a guy 1,500. When I was 942, I got a scare. My cholesterol was higher than my address.
ANNOUNCER: Have your cholesterol level checked, and, if it's high, learn what to do about it. Remember, it's your health, it's your life.
BROOKS: It's your move dummy.
ANNOUNCER: A message from the National Cholesterol Education Program.

MS. BELLICHA: The premise of the spot fits our message well. If the Two Thousand Year Old Man managed to survive such a long time by watching his cholesterol, maybe we should pay attention and do likewise. And that's also one of the social marketing lessons that we've learned — it pays to pay attention to the survivors.

Avrahan Forman

National Institute of Drug Abuse

Avrahan Forman is Deputy Chief of the Community and Professional Education Branch for the National Institute on Drug Abuse (NIDA). He supervises the Institute's program of education for the general public on NIDA's drug abuse research through the mass media. Mr. Forman's education and his early professional background were in social work and public health. He has worked in the drug abuse field for more than 15 years. His professional experience includes training, the production and marketing of national media campaigns, and the creation and management of the National Drug Abuse Information and Referral Telephone Hotline.

In my agency, social marketing has not proceeded along very smooth lines or a very smooth path, although we've engaged in lots of activities and used lots of tools from social marketing, and I think we've really been successful.

Before I describe some of our activities and the problems that I see, I would like to try to put my subject — drug abuse — in context. Drug abuse has occupied the American public greatly for the past 25 or 30 years.

Before 1965 or so, drug abuse meant heroin addicts. They were relatively few in number. Jazz musicians and a few deviants who smoked marijuana were also included. After the revelations of 1965 to 1968, drugs were on everybody's minds and in lots of people's bodies. The drug problem, as you all probably know, gained great visibility in America because it became an issue and a symbol of concern having to do with deviance and a challenging of social norms. Its significance went beyond the individuals who were using substances to alter their states of mind. It had a lot to do with changing America and changing what's right and what's wrong. From society's point of view, it became a challenge to social control.

As a matter of fact, I guess it was the Nixon administration in the 1960s that really formed the first office — national office — to attend to drug abuse problems, because of the concerns about all the people out on the streets who were using drugs and doing things that we didn't want them to do on the streets. In addition to that, there was a recognition even earlier, and certainly as we've progressed in time, that drug abuse is a problem of health and that people who are drug abusers need health care. This has hit home particularly, I think, in the past five or six years as we've recognized the relationship between drug use and AIDS and HIV transmission.

The agency that I work for, NIDA, is a medium to small agency in the Department of HHS, located in the Public Health Service. NIDA was formed in the early 1970s to attend to the drug abuse problem. We had responsibility for training and organizing drug abuse workers, making sure that services were available to drug abusers, organizing prevention operations, making sure that people did not start using drugs, and performing all kinds of drug abuse research.

That role has changed over the years. Today, we are responsible primarily for conducting research into the causes and effects of drug abuse and its treatment and prevention. We don't have responsibility for treating drug abuse, and we don't have responsibility for preventing drug abuse. The reason I'm telling you this is that while we don't have that responsibility, we're doing a lot in terms of public education and some of these activities could be described as social marketing.

As the organization of our government and our agency has changed, there has been a shift in the primary focus of our agency, and with it we have more problems getting our educational messages across. Despite that, I think we've been quite successful.

During the past ten years, we've conducted five national media campaigns, among them the "Just Say No" campaign, which gained lots of fame because the slogan became the watchword for prevention. First Lady Nancy Reagan told the youth of America to "just say no." Later it became a target of criticism because just saying no is not enough. But when the campaign was launched, it was the first effort that the government had made. It was successful in appealing to mainstream kids — many of whom were experimenting with drugs — with the notion that peer pressure is something that can and should be resisted and even with some suggestions for how to do that.

"Cocaine — the Big Lie," was our second big campaign, which we launched just as the cocaine epidemic began to make itself known. In addition to developing PSAs that told of the addiction potential and dangers of cocaine, when scientists had been saying that cocaine was not an addicting drug, we also connected a national hotline to that campaign. The hotline allowed people who were hearing messages about the dangers of cocaine and appeals to get into treatment to call and talk to somebody who could give them confidential, sensitive, skilled counseling and get them moving along the path from considering quitting drugs to actually entering a treatment program. Ultimately, they were given the names and addresses of treatment programs, but that was the least of it.

Since then we've focused our activities on drugs and AIDS. "Stop Shooting Up AIDS" was a campaign that we launched in the late 1980s, at the time that the "C" word was hotly contested, and nobody was talking about condoms on television. We decided to reach out to needle-using drug abusers — hard-core heroin addicts for the most part — with information about the dangers of sharing needles and the need to use condoms.

We didn't do it on television because you couldn't get the "C" word said there, but we did do it with print materials, which we combined with an outreach campaign. Street workers actually went out on the streets and collared active drug users who were not in treatment, gave them our material, and talked with them about at least — well, talked with them about getting into treatment and, if they were not going to stop using drugs, talked with them about how to practice safer drug use, and certainly safe sex.

We have advanced since then and launched a campaign that's just gotten under way within the past year called "AIDS and Other Ways Drugs Can Kill." Now we're no longer as concerned with HIV transmission through contaminated needles as we are with the effects of drugs on people's consciousness and their ability to make sound decisions. We are becoming more concerned about people getting into situations in which HIV is transmitted. That is to say, people get drunk or high and engage in high-risk behaviors and risk getting HIV. These ads are on television, and they are quite powerful. We were lucky enough to have Martin Scorsese and Spike Lee work with us on the television productions. We think we have a campaign that's reaching a lot of kids.

We're also engaged in a campaign and a partnership with several local and state organizations to sell drug abuse treatment. The "Drug Busters" project is aimed at overcoming the barriers to treat-

There was a recognition, certainly as we've progressed in time, that drug abuse is a problem of health and that people who are drug abusers need health care.

ment. We've combined a series of radio, television, and print materials to support community organizations that promote drug abuse treatment in their local communities and try to overcome the "Not in My Backyard" syndrome. People don't like drug abuse treatment centers in their neighborhoods, and we're trying to organize communities to overcome that.

In addition, during the past five years, the national hotline that I told you about has served more than 350,000 people. About half of those callers are active drug users who are in some stage of a continuum in deciding to stop using drugs. Some people call up and just want to know what treatment is about; others are anxious to get names and telephone numbers. Everybody, though, gets a counselor who can help them move along that continuum.

So the program goes from putting information out in a television ad that takes 30 seconds and gives somebody a brief message about the dangers of cocaine or other drugs, to allowing them to call in and talk for up to 20 or 30 minutes. For callers, information needs to be fine-tuned in a one-on-one relationship. We've also organized a network of state and local organizations to help promote and use our materials. But, more importantly, they're beginning to learn how to develop health education materials of their own about drug abuse and AIDS.

I just want to talk for a couple of minutes about the problems and obstacles that we ran into as we tried to get our programs going. First, there's the question of credibility. The image of a federal government agency talking to people who use drugs and giving them information about drugs being dangerous tends to be suspect, to say the least. The same is true even when we're talking to parents of drug users. I don't think the image of federal government agencies is always high among the general public. People often suspect the federal government and the people who work for it.

Back in the 1970s we told young folks about the dangers of marijuana, and we told them that marijuana could cause genetic diseases and all kinds of other things. They certainly didn't believe us, and much of that really didn't pan out. When we came up against that same audience ten years later — now 25 and 35 year old cocaine users — we had to talk to them again about the dangers of cocaine. That was a problem.

Now we're no longer as concerned with HIV transmission through contaminated needles as we are with the effects of drugs on people's consciousness and their ability to make sound decisions.

Generally it has been very difficult to get drug users to hear and act on our messages about any kind of drugs. For us, the most important issue has been to use solid research-based information that we knew was true. We found — or rather our researchers found — that cocaine does indeed affect the brain in a certain way that is addicting. We were able to use that information in ads that were powerful and straightforward. We spoke with people who had suffered real problems, and they told their stories in ways in which people could identify.

In addition, we were able to connect people to the hotline, so that they were not left only with the message, "don't do drugs" or "don't do cocaine." They were allowed to call in for counseling. Also, our timing was such that John Belushi had just died. And, when our ads began to run, Len Bias had overdosed

and died of a heart attack, which is just what our ads were talking about, so our credibility increased.

The second problem has to do with access to channels of communication. We rely a lot, and I think my colleagues do too, on television PSAs. They are the best way to reach a lot of people. Television is getting crowded. Marketing on television — commercial marketing on television — is very crammed, particularly this year, because the markets are off and it's difficult to get people to run public service ads. In addition, the target audiences for our messages are getting saturated and jaded. They've heard a lot about drug abuse and its evils.

Television is getting crowded. Marketing on television — commercial marketing on television — is very crammed, particularly this year, because the markets are off and it's difficult to get people to run public service ads. In addition, the target audiences for our messages are getting saturated and jaded. They've heard a lot about drug abuse and its evils.

Related to that is the privatization of social marketing in the drug abuse field. The Advertising Media Partnership, which created the ad about fried eggs and many other famous ads, has produced about 300 ads and has been broadcasting them during the past three years. The firm will probably produce

another 200 during the next two years. That is a lot of advertising, and the partnership has been able to garner dedicated time to show them. People are hearing a lot about the subject, and it's hard for them to listen to our ads too.

Also, national campaigns are distant from local media targets. It is difficult to get local station managers to play messages if they don't know about the subject and if it's not pertinent to local happenings. We've tried to overcome that by working with organizations like the Ad Council, which you are probably familiar with. It enjoys a good reputation in the field and helps us get our pieces played. We've built alliances with the private sector, particularly with the Advertising Media Partnership, and with new groups that are starting up. Even as we speak, there's a new Advertising Against AIDS Coalition.

We've built networks with state and local groups, and we've worked with them to market our materials. But, more importantly, we've helped them develop their own. We're trying to get creative with our use of the media. Television is not the only answer. Movies can get public service messages in front of a lot of people quickly. We're trying to use more radio and some clever print materials. The hotline certainly allowed us to get more detailed information into the ears of people.

The last problem that we've had (and we all probably share this) has to do with agency leadership. In the federal government, social marketing is not necessarily a prime focal point: that's not the mission of most agencies. My agency, in particular, is concerned with drug abuse research. In addition, over the years, there have been turf and territory problems. New agencies form and take on responsibilities for issues that we have been responsible for. During the past five years two new agencies have become responsible for drug treatment and drug prevention. They also want to do public education. Agency leadership doesn't like conflict among their agencies.

What we've done is to develop and keep access to our leadership. It's important for the director of our Institute to understand the advantages of social marketing, although we don't call it that, as a way of keeping the image of the agency out there and relevant in the United States. It has something to say about drug abuse and gets good solid information to people. It's important for the leadership right up through the Department to understand that social marketing and public health education are ways to do something about public health problems. We've also worked hard to try to coordinate our efforts with other HHS agencies.

Where are we going with social marketing? I can only speak for my agency. From our viewpoint, I think it's getting more and more difficult for us to justify spending the money that we spend on large media campaigns. I think we're going to be relying more and more on the private sector to do that, and we will try to coordinate with them, in partnership with them, to help them with information, and to try — even though we don't control the agenda — to help set the agenda and the tone.

We're also going to be working more and more to teach local groups how to do social marketing in their own areas, and then let them do it. Let them set the agenda as they set up meetings in local areas, and then let them use their local resources to carry it out.

Nancy Pielemeier

U.S. Agency for International Development

Nancy Pielemeier is the Deputy Director of A.I.D.'s Office of Health in the Science and Technology Bureau. She oversees programs ranging from Child Survival to Communicable Disease Control, including AIDS Prevention. Many of these programs have very important social marketing components. She was previously a Senior Health Advisor in A.I.D.'s Policy Bureau, where she was responsible for child survival and the Agency's nutrition, health, and AIDS-related aspects of policy development. Dr. Pielemeier holds masters and doctoral degrees in public health from The Johns Hopkins University School of Hygiene and Public Health, with an emphasis on international health/nutrition education and social marketing.

I'm going to talk about some of the federal government's international experience with social marketing within the Agency for International Development (A.I.D.), which is the agency through which your foreign aid tax dollars are channeled. In A.I.D. there really has been an international leadership role for the concepts of social marketing. The Agency in general is favorably disposed toward the concept, based on a fair number of successes and good experiences with its application in different sectors.

Even so, as Bill Smith alluded to earlier, there are some for whom the concept remains slightly suspect. Partly because of the terminology. The association with social engineering, or something that vaguely resembles socialism, bothers some critics. For other critics, the subsidy aspect of social marketing, particularly in promoting the use of donated or subsidized commodities, is a less than perfect fit with the concept of free market. However, despite this terminology, both the concept and the name have managed to survive during nearly two decades within A.I.D. A few words about the contribution of social marketing, particularly in our health-related foreign assisted programs.

Social marketing has helped improve the look of our products like this package of oral rehydration salts (ORS) transformed from a drab package to this colorful and attractive package through consumer research. In Pakistan, we are picking up on the public-private partnership approach, and getting local and international producers to contribute to and sponsor the ORS pharmaceutical campaigns. The program materials were all produced by the multinational or the local producers in Pakistan, and it became quite competitive. This was a way for the companies to show their goodwill and their interest. They developed a range of things, including new kinds of dispensers for mixing and administering oral rehydration salts. We have a list of over 15 collaborating companies in this particular campaign in Pakistan. There are a number of large multinationals as well as local producers.

One thing that we have sometimes remembered, and sometimes forgotten, as we have transported the concept of social marketing from packaged products like condoms or ORS salts into other sectors, is making sure that the supply is intact before introducing the promotional campaigns. We have found it to be important to stress production, distribution, and storage aspects of programs to ensure that demand is not stimulated where there is no supply. We have found that integrated programs are effective and sustainable, while isolated marketing efforts are, at best, successful in the short term. This sounds like a truism, it is a truism, but it is remarkably important to remember in any kind of social marketing.

Social marketing most often means selling what is good for you; not necessarily what tastes great, feels good, or looks cool. Selling Coca Cola is clearly easier than selling oral rehydration salts, even if they are flavored. Selling alcohol or tobacco is easier than promoting exercise or condoms. Marketing Air Jordans is much easier than promoting bike helmets or

seatbelt use. In fact, the current debate revolves around how much media advertising directed to consumers is required to promote health products and concepts. And, what is the relative advantage of reaching influentials — notably physicians, pharmacists, and other direct retailers? Where does social marketing begin or end and where do other disciplines take over, particularly in a situation such as ours, where social marketing is very closely associated with the concepts of advertising and media use?

> *We have found it to be important to stress production, distribution, and storage aspects of programs to ensure that demand is not stimulated where there is no supply.*

What about other, less exciting but more traditional methods of getting the message across — alternatives such as the old extension agent approach the training and visit system that has been used successfully in marketing oral rehydration therapy in Bangladesh through a program of the Bangladesh Rural Advancement Committee and through an urban volunteers program in Dacca?

What about in-school education — teaching youth to use oral rehydration therapy and getting them to take that information home? What about AIDS prevention education, directed at in-school youth? And finally, what about the tried-and-true concept of counseling with one-on-one information and dissemination — particularly in AIDS prevention, where behavior change is essential and sustained behavior change is required? How does counseling compare with social marketing?

Where is social marketing going in the international field? When social marketing was developing as a concept, it was assumed that subsidies would be required to make the commodities affordable to target groups. A focus on a single commodity or brand name and a single distributor, which also minimized our management burden, were the key ideas. But recent experience with ORS, as I alluded to in the Pakistan example, is demonstrating that competition among producers and their willingness to improve or enhance their corporate image mean that promoting the concept, and not a specific brand, may be what is needed. Thus, there may be a reduced requirement for subsidizing products or using donated commodities.

Another area in which the public sector can make a contribution is the whole concept of improving product attributes.

If this is the case, then the pricing policy becomes very important. The line between self-sufficiency, sustainability, and missing the target audience is a fine one. This then points to the need for continued monitoring and research to determine who is getting what, who is using what, and how successful our efforts are — however they may be targeted. This indicates to me that a continuing role for the public sector over the long term may be in making sure that the research is there and that monitoring continues.

Another area in which the public sector can make a contribution is the whole concept of improving product attributes. With many of the social products we promote, prices and profits are

already low. Producers may find that it is not in their interest to spend a lot of money on product improvement with marginal profit increases. They may find that promoting these products is beneficial to their corporate image, but may not be worth their research dollars to invest in improvements.

This, then, may be another area in which the public sector can have a continuing interest. Experimenting with flavored oral rehydration salt solutions is only one example. Developing oral rehydration therapy that reduces stool output for children who are having diarrhea is a desirable attribute mothers are looking for. Products don't provide it!

My hunch is that support for development and adaptation of technologies like this will need to be a continuing role for the public sector in the social marketing partnership that we see developing between private and public sectors.

Beverly Schwartz

Centers for Disease Control

Beverly Schwartz is the Social Marketing Specialist with National AIDS Information and Education Program at the Centers for Disease Control in Atlanta. One of Ms. Schwartz's major responsibilities has been to develop specific marketing and implementation plans for the America Responds to AIDS television, video, and print campaign that all of us have seen. But recently, CDC recognized the broader implications of social marketing and has expanded her responsibilities to marketing the overall HIV/AIDS information and education program at CDC. Her career in health includes the implementation of programs involving advocacy for nonsmokers' rights, adolescent smoking prevention programs, and free eye care for the elderly. Beverly is one of those rare social marketers who actually worked on the "other side" as an account executive in the commercial sector, where she helped bring us A-1 steak sauce and Ortega Mexican foods, as well as working on accounts for a state health maintenance organization, a regional hospital, and Williams-Sonoma.

I want to thank AED for the opportunity to share with my colleagues and the audience some of my perspectives on the social marketing function within the federal government. Though much of what I discuss will have applicability to other federal programs, my perspective is based on working on an issue that has many highly political and controversial aspects.

Educating the American public about HIV and AIDS makes me very envious of my fellow panelist, Terry Bellicha, who markets heart disease and asthma programs. They do not — I don't think — have a "C" word to worry about.

MS. BELLICHA: Well, we do have a "C" word, "cholesterol."

MS. SCHWARTZ: Yes, but you can say it, can't you? I can only **think** our "C" word.

MS. BELLICHA: Well yes, I can say cholesterol, I just can't talk about food.

MS. SCHWARTZ: So we all have our problems. Our ultimate goal, however, is to use social marketing to reach the "human" in human services. It is easy to lose sight of that goal when faced with institutional barriers. Complicated layers of hierarchy and the overwhelming levels of "players" involved in any one program decision can be as frustrating as it is problematic. Within our federal environment there exists a unique subset of obstacles that directly influence the outcome of social marketing programs. I have identified five obstacles I think are common to our programs.

The first obstacle is that very few government officials at the higher decision-making levels of our agencies understand the fundamentals of marketing. Nor do they particularly want to understand the fundamentals of marketing. Marketing is very foreign to "business as usual" in public health practice. It makes most people uncomfortable to have to deal with a foreign subject like "marketing." It is very different from the science-based theory or medical models with which public health is accustomed. If decision makers do talk about marketing strategies, the strategies are often classified as something that would be really nice to do, but not necessary.

This situation often reminds me of the "essential versus desirable" analogy that I once heard discussed at a public education meeting. "Would you rather have your children walk to school or be bused to nowhere?" In marketing I think of it as, "Would you rather have your program marketed or develop materials that really look great sitting on the shelf?" I think there is a lot of this "essential versus desirable" conflict going on in the federal government level.

> *Marketing is very foreign to "business as usual" in public health practice. . . . It is very different from the science-based theory or medical models with which public health is accustomed.*

The second obstacle is that in dealing with health matters, we often have limited opportunities to market to specific target audiences when we are also mandated to have relevancy to the total population. Add to that problem the inability to place media due to the non-paid public service nature of the government programs and your ability to market to the specific audiences is significantly hampered. Because of this, reach (which tells you how many people hear your message) and frequency (which tells you how often you reach them) are rarely discussed as part of the initial marketing strategy. They are usually discussed only as a way of evaluating the effectiveness of the media program. Since you are unable to build specific reach and frequency strategies into your media plan, the "who" and "how many" you are trying to impact becomes less than an exact calculation.

Obstacle three is time. Dealing with the institution of government takes an incredible amount of time. When you talk or even think about marketing strategies involving the development and clearance of mass media for a high profile issue it takes a very long time to plan, develop, implement, and evaluate a program. And it can take even more time to fine-tune a program for evaluation results. A lot of that time is spent dealing with individual approvals and institutional clearances.

Then, of course, if you deal with government marketing, you must also understand the Government Printing Office. This is an office that is bound by government practice to bid out print jobs and generally take the lowest print bid. This process can be slow and torturous and unpredictable. You must always plan way ahead when working with the government printing system. Normally, this is a good rule to follow when printing any materials, inside or outside the government. However, in the government, getting materials to the printer is dependent on a cumbersome clearance process which always takes two to four times as long as you anticipate, no matter how much time you originally allotted.

Obstacle four is what I call the "principle of backseats." Communication principles and communication values often take a backseat to science and medicine. Networking, collaboration, and partnership building activities often take a backseat to the visible creation of media materials, much of which are electronic.

The fifth and final obstacle is that the "hard to reach" are often as not our superiors. So what can we do about this? What we can't change is the corporate culture that exists in each different agency. At CDC, science and epidemiology set the context in which everything revolves. You must understand that context in order to be able to develop effective marketing strategies. I would like to suggest that social marketers accept the responsibility to "market" marketing to public health officials. We must pay attention to and understand the politics and process of decision making within our agencies. Political climates and agendas need to be managed from the beginning to the end of the marketing process. We must use that knowledge to design internal marketing strategies before external marketing can be implemented to its full effectiveness. We must also make good use of theoretical underpinnings and published literature on communications and marketing — use solid data to convince our colleagues that

communications and marketing are sciences in their own rights. Though we know that a certain percentage of good marketing is based on instincts, we really have to back up those instincts with some valid data that public health professional people can understand.

I would like to suggest that when we speak about marketing in our agencies, we speak about marketing as an integrated process. We must explain strategic marketing principles and objectives as a coordinated, collaborative, and supportive venture. I often see us give out a laundry list of potential marketing activities and strategies that can easily get pared down in a haphazardous way by superiors who do not understand which program elements depend upon the others for success.

If you have ever worked in the federal government you know that as resources tighten, the relationships with institutional partners in the private sector and the community become increasingly important. Local intermediaries become one of the most efficient ways to use federal dollars to reach the public. I think that many of my colleagues have mentioned that. They have spoken about the use of partnership and intermediaries as a means to accomplish objectives. But the point I want to make is that the use of local partners is not only a strategy for implementing programs, but also for sustaining programs. We need to think of partners as true partners and work with them continuously throughout the entire marketing process, and not only for one-time assistance in implementing initial activities. We must build activities with them that last well after a program is launched. It is prudent to remember that intermediaries can be used as valuable resources, but underutilized, they become sources of dissension, disagreement, disappointment, and political pressure.

As I look into the future, what I'd like to suggest is the need for better logistics planning for distribution. The principles

> *Communication principles and communication values often take a backseat to science and medicine.*

of distribution and logistics around distribution of both messages and materials is critical. On the national level, distribution strategies need to be efficient and sensitive to the intermediaries. Materials need to be easily available and accessible for the target audience. I would also like to suggest that we approach market segmentation with a more creative mind. Ever changing government resources and the new priorities of changing administrations layered on top of evolving American lifestyles place added value in finding new segmentation philosophies and concepts. Sometimes segmenting by attitudes instead of demographics can provide a more defined and easier-to-access audience.

I strongly believe in the worth and benefit of using the social marketing process to promote healthier behaviors. If I believe that and also work within the federal system, then I need to be challenged by the system to modify the marketing program to meet the objectives and leverage the unique opportunities found within each particular agency. I must develop the most effective marketing plans possible under the circumstances we all have to face each day.

I foresee that for social marketing to have an acceptable place within the federal system, we will need to approach our jobs with creativity, using an incredible amount of innovation to get marketing objectives defined and accomplished, always accompanied by an increasingly important sense of humor. Thank you.

Sharyn Mallamad Sutton

National Cancer Institute

Sharyn Mallamad Sutton is Chief of the Information Projects Branch, Office of Cancer Communications, at the National Cancer Institute (NCI). Dr. Sutton's social marketing priorities at NCI include the early detection of breast and cervical cancers; public cancer information initiatives, particularly for underserved populations; and programs for cancer patients, their families, and health professionals. Prior to joining NCI, Dr. Sutton was Executive Vice President at Porter/Novelli, one of the most experienced social marketing communication agencies in the U.S. At Porter/Novelli, Dr. Sutton was responsible for research and strategic planning. She was involved in many federal social marketing programs, including those for high blood pressure, cancer, cholesterol, and family planning. We are particularly proud to note the role that Dr. Sutton played in the early days of our collaboration here at the Academy with Porter/Novelli on our international child survival communications program. Dr. Sutton received her master's and her doctoral degrees in psychology from the University of Maryland.

I think I may have figured out why they have ordered us this way at the speakers' table. The people at the other end are reflecting on social marketing from a government standpoint. Given my background and experience, I am going to reflect on what social marketing looks like from a commercial marketing point of view.

I have marketed Franco American Spaghetti-O's, Gillette razor blades, Kitty Litter, Audis, and ITT computers — you name it. My position at Porter/Novelli provided me the opportunity to watch many major companies — big companies like McDonald's and General Mills — and see how they marketed their products. It was absolutely fascinating. But then I would come back to my social programs, get frustrated, and say, "Why can't I do the same things on this program? Since there are effective methods out there — and the rest of the world is already using them — why are **we** not using them on programs that are so much more important?"

Then a couple of years ago I moved over to the government side — the NCI. I'm not here to present the Institute's view on social marketing or to talk about cancer. Rather, I'm just going to talk about what I have seen and experienced as a social marketer.

When I decided to go into the government, I was really interested in seeing whether or not social marketing worked, because that is what the literature kept asking: can it work? Can social marketing be used to solve social and health problems? Many people have focused on, say, the difference between the world of McDonald's and the world of breast cancer. "Oh, social marketing is not going to work because our products are different. We are telling people to do things they don't like — or the behaviors we focus on are much more complicated than what's asked of people in commercial marketing." I want to say that's baloney! The products and the behaviors that people are dealing with in the private sector and on the commercial side are just as hard and just as complicated as those social behaviors that we are dealing with. And it is becoming more so every day.

I think A.I.D. has done well in its social marketing efforts, because they have often had tangible products. It makes sense. Products fit traditional marketing practice. At A.I.D. we would market pills or oral rehydration salts (ORS). As opposed to marketing nonsmoking or early detection of cancer, which are not tangible, ORS seemed easier. But now, I am not so sure. There may be much less difference between what we are marketing on the social side and what we are marketing on the commercial side. The research that has been done suggests that tangible products versus non-tangible benefits may not be the real difference. With or without a product, consumer awareness and behavior are impacted by the marketing process. The structure of the marketing exchange may be less obvious in the social sector compared to the commercial sector, but everything we do to

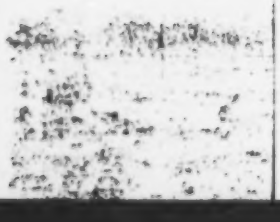
facilitate that exchange is interchangeable.

I think one of the few real differences between social and commercial marketing programs is the organizations in which we are working. I would like to focus on this area and identify what I think might help us move along.

The products and the behaviors that people are dealing with in the private sector and on the commercial side are just as hard and just as complicated as those social behaviors that we are dealing with.

There is a huge clash between the people in the marketing world — the private commercial marketing side — and the social service culture. It's a clash because we don't understand each other and there is very little transference or diffusion between the two very different worlds. I can probably count on one hand the number of people I know who have come from commercial marketing backgrounds to the social side. Most of the people you see as social marketers tend to be social scientists or public health people who "got religion" and are now doing it.

I recently spoke on marketing along with representatives of three big private sector social programs: Partnership for Drug Free America, MADD (Mothers Against Drunk Driving), and Broadway Cares (an AIDS groups in New York). My job was to explain social marketing to everybody, and when I was done three of the other speakers came up to me and said, "You know, I had never heard of social marketing before this conference. I am



so glad that there are people out there thinking about it." These people didn't know they were doing "social" marketing. They were just marketing, and happened to be focused on a social issue.

As I said, there is a big gulf between these two worlds. The social service culture think that marketing is suspect. The marketing people don't always respect the social service people. Both groups believe that the other has no idea how complicated the framework is in which they have to work.

Here are a couple of examples from the literature about this conflict. Larry Wallack, a social scientist, has written often on how "Social marketing has been criticized as being manipulative and ethically suspect." In response, Dick Manoff suggests, "To avoid a crass commercial association, use such euphemisms as social communications, nonformal education, social promotion, political technology — any label that avoids any hint of linkage to marketing." For those of us who want to go over and work on the social side, that's not a good answer. We can't just change the title.

I want to convince you that marketing is neutral. Marketing is a technology, it is not good or bad. It depends upon how you use it. An analogy would be engineering. It offers approaches, principles, and systems for building structures. An engineering plan that follows established principles is not inherently good or bad. However, its worth depends on the way technology is applied and adapted to various building materials and site requirements. And so it is with marketing. It is neither inherently good nor bad but only a technology that can be used to achieve goals of varying worth.

Marketing is a problem-solving, systems approach. It is an orientation to the world and it is a management system. Its

orientation to the world focuses on the needs and wants of consumers. The management structure is designed to address and solve problems. I'm not saying that marketing is the only strategy to change behavior. There are many strategies for social change: technological, economic, political, legal, educational. Smoking can easily illustrate this point. Technology could solve the problem of smoking. If we had a cigarette that didn't hurt anybody, smoking would no longer be an issue. There are economic behavior-change measures. If people couldn't afford to buy cigarettes, smoking rates would go down (as we saw in California when 25-cent increases were mandated). There are political and legal strategies. As it becomes harder to find a place to smoke, people smoke less. Education also can affect smoking behavior — with school-based programs and physician intervention programs being good examples. However, as separate strategies they have limited effectiveness.

Social marketing lets us take these different strategies together and combine them for greatest impact. My favorite definition of social marketing — that I would like to take you through one step at a time — emphasizes this role. First, "social marketing is a social-change management technology." And I wish to emphasize the element of management. As a management system, Kotler has argued that social marketing can orchestrate and render effective the piecemeal strategies described above as components of a comprehensive social marketing program.

If social marketing is done correctly, it is a long-term, managed program. And if it isn't long-term, then it's not what I would call social marketing. It would be just a another isolated strategy.

The second aspect of the definition is that "social marketing uses marketing concepts, systems, and tools." And there are

a lot of them: consumer orientation, exchange theory, consumer research, market segmentation, product and concept development, product and concept testing, directed communication of benefits, process evaluation, just to name a few. The difficulty is that many of these tools are often overlooked by those wishing to practice social marketing. We've also heard a lot today about mass media, PSAs, communications, and educational materials. But these are just one small slice of the social marketing discipline — just several of the tactics available to us. There is a whole universe of other tools and principles for us to apply to social and health problems. Concepts like consumer orientation, or exchange theory, or market segmentation, are critical to but overlooked by many social marketing programs. These tools are rarely used or even understood in the social service sector.

Third, "social marketing is a way to change the behavior of a targeted group of people." I think that's really important for two reasons. One, because it states that we cannot meet the needs of "the public" within any one program. We must segment, we must set priorities. Two, because when we concentrate on behavior change, we must also address the entire program, not just education. Now there may be changes in audience awareness and changes in knowledge, etc., along the way, but social marketing does not focus just on messages and teaching people "to do the right thing." It is very much behavior oriented.

Finally, social marketing is found in programs that are done in the best interest of the individual and society. You can say, "Well, who decides what those are?" My best answer today is that our government is responsible for deciding what is in society's best interest. I realize that is an exceedingly shallow answer for a very complex debate. But my point is that the discipline of social marketing does not carry with it a social agenda. While it has the tools to help identify solutions to social problems, "somebody" must still make the decision of what is in our best

interest. Social marketing then becomes the tool to help us move from point A to point B. Social marketing in and of itself does not have an opinion on what is in the best interest of the individual or society.

I believe that in the **intent** of the program lies the other real difference between social and commercial marketing efforts. I like this quote by Lefebvre and Flora: "Marketing and social marketing distinctions can be blurred. It is necessary to clarify whether one is interested in increasing market share, versus improving public health." I met with Craig Lefebvre the other day and he told me of a friend of his who works for a health care company. His friend said that he was on the side of the angels, because he is out there marketing a product that's really helping people. It's a medical product. People really need it and it's really doing social good. He said that his company is also making a ton of money. Then Craig asked me, "Now, is that a social marketing program?" "No," I said, "it's not a social marketing program." No matter how good it is for people, if as soon as you stop making money they're going to stop putting that product on the market, then the **intent** makes it a commercial marketing venture. The IUD is a very good example of the distinction. The IUD is a product of social marketing programs in the Third World where we're promoting it for family planning. But it's no longer available in the U.S., because liability suits now outweigh the benefits for those companies selling them here.

Social marketing does not focus just on messages and teaching people "to do the right thing."

Maintaining a social intent is not easy. Philip Kotler has discussed how organizations move through a motivation and maturation cycle. An organization starts with a core of people who really care about something and are there to change the world. If they are successful, eventually the "business" people have to come in to manage it, and then there's the next generation of employees, and the next. You get to the point where the institution has "forgotten" what its original mission, or purpose, was. The goal becomes to stay in existence, maintain "image" and profitability.

It is unbelievable to me, for example, how much conflict and competition there is among the different groups out there with the same objective — to help people with cancer. Splinter groups are breaking off from the "established or mainstream" organizations. Cancer survivors are saying, "You know, I won't have a thing to do with ACS. They don't care about us. We're going to start our own organization that really cares about cancer patients." But it's not just ACS. Any organization that loses sight of its mission loses sight of its constituencies, its consumers. And the response is inevitable. Consumers look for or create one that is responsive to their needs. Then, of course, the "old" organization has to fight the "new" one to keep membership and cash flow positive. And where's the patient? Needless to say, while the mechanisms for maintaining existence differ, government agencies that lose sight of their mission meet with the same fate.

I'd like to finish today by addressing two of the biggest challenges for improved social marketing in the government. The first I will call the "intervention clinical trial." The foundation for most government social interventions is medical/scientific/research disciplines. Given this framework, we mistakenly apply the basic research model as the means for arriving at our social interventions. This intervention clinical trial seeks to determine effective interventions through experimental designs that ma-

nipulate variables in a controlled environment. This tradition is based on the false assumption that the experimental interventions can then be replicated in "real life" to achieve the desired social or health goal. This is rarely, if ever, the case, for many reasons — but that is a different speech. Yet this process takes many years and consumes tremendous budgets, budgets that could be applied to the intervention. I don't mean to imply that the commercial sector does not rely heavily on research. However, the model is dynamic and systems based, not a controlled experiment.

What is most ironic is that the interventions being tested investigate methods commonly used in the commercial sector. For example, reaching minority audiences is a high priority for many social programs. Millions of dollars are being spent on numerous studies to figure out how to communicate and influence these groups. But why? People are reaching minorities every day. Look at Nike, Colt 45, the cigarette companies. It's not a secret. But if you ask: are these social programs based on the needs and wants of the targeted segment? Do they regularly work with the minority media? Have the programs been geographically targeted within those areas where a high proportion of minorities live? If they have done none of these things, then I say, why not use the funds to do these

Any organization that loses sight of its mission loses sight of its constituencies, its consumers. And the response is inevitable. Consumers look for or create one that is responsive to their needs.

things first — then if they don't work, we can always spend the money to figure out how to reach minorities.

The problem, of course, is that you can never take the research money and apply it to an intervention program. There's always so much more money to research problems than to actually address them. That's one of my goals; I want to get that money for the programs, not research.

A number of social marketers went to the University of South Florida about a month or so ago to participate in a conference on social marketing within the government. Everyone participating seemed so interested and positive toward social marketing. But there was something I didn't understand, so I did a survey of the participants. I asked, "If social marketing has been used for over two decades, why do you think public health agencies have not adopted its approach?" These were some of the typical answers I received:

Fear of advertising; no budget for advertising; limited budgets; do-gooders who feel people will just do the right thing.

Public health agencies have not received the necessary information from academic institutions and advertising agencies.

Public health agencies lack funds to implement social marketing.

This emphasis on advertising and communications is often the fault of the presenters — when giving a speech on social marketing, it is so easy and such a temptation to bring your reel, your PSAs, print materials. All they see is communication. People walk out thinking that social marketing is advertising; social marketing is communications. They miss the core of what social

marketing is. It is consumer driven with an exchange theory. That's the message that never really gets across. But, as my friend Alan Andreasen says, "Social marketing is a point of view. Even if we don't have a big budget, we can do social marketing with what we have because it's a way to approach a problem."

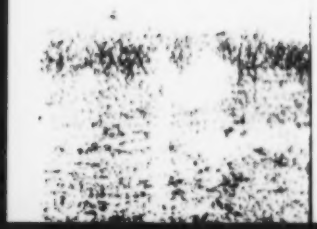
Several responses addressed the organization, such as:

> *Public health agencies have most often organized and managed according to military or medical models, which concentrate decision making at the top, and are guided by professional wisdom rather than consumer needs, desires, and input.*

And this last one, my favorite, describes what I believe is the other major obstacle limiting social marketing's impact within the government.

> *In my State, public health agency personnel received their education before the social marketing movement, or perhaps it was so new that their professors knew nothing about social marketing. We do what we know and we often know mostly what we've learned in school. It will take another generation of learners before practitioners feel they know this.*

Going to Florida for three days didn't turn those people into social marketers. The issue of training is a very difficult one. Let me share one more informal survey that I did among my fellow social marketers — this one really surprised me. I wanted to know how they got into social marketing. What I found was that 95 percent said they got into social marketing by accident. Two percent had "founded" social marketing (Bill Novelli and Dick Manoff). Three percent they said they didn't know how they got into social marketing.



In summary, this is where I think the challenges are and I want to tell you, my two years have been challenging at the National Cancer Institute. It has also been some of the most exciting work that I have ever done. It has been wonderful, because what I have seen is that we can go in, use marketing, and it works. You can do commercial marketing things, and social things happen. You target the African-American media, and the African-American media covers you. You use a spokesperson who appeals to the African-American media, such as Spike Lee, and you never have to say it was a National Cancer Institute message, but you can get it communicated.

What I found is that I've been asking the wrong question. I shouldn't have asked, "Does social marketing work?" because it does work. The only reason one might think it does not work is if you read the academic literature. So I advise you: don't read it. The questions we should be asking are: How do we improve our social marketing efforts? How can we as government workers get together and get organized? If we haven't been trained, we need to go back and get trained. We need to go back and figure out how to apply these concepts and strategies in our programs and not just in the creation of PSAs and materials. We need to figure out how we can best organize for success, because until we can get (and this may be me trying to change the wind) the people who are involved in breast cancer in six different agencies to talk to each other, we're not going to be organized for success. Finally, how do we create more social marketers? That's the important thing. How do the old heads who have already been through school get religion? Go back and get the training you need to make social marketing a reality today. Thank you.

Porter/Novelli

Porter/Novelli (P/N) is one of the leading social marketing firms in the U.S. Their work for NHLBI, NCI, and A.I.D. has been a model of public-private partnership. Since 1978, P/N has served as a subcontractor and partner with the Academy in the development and adaptation of social marketing to the needs of resource-poor developing countries. In preparing this publication, we asked Mary Debus, Vice President for International Programs at P/N to reflect on the future of social marketing in a changing world.

Social Marketing in a Changing World:

A Private Sector Perspective

Twenty years ago, when Philip Kotler first began writing about social marketing, and Bill Novelli first began practicing it, the "marketing environment" was substantially different than it is today. Dramatic changes in technology, service delivery, clinical practices, the media environment, and target populations have altered what social marketing efforts can and should be doing — as well as the way to go about doing it.

Smart marketers — social or commercial — recognize that to be successful they must stay ahead of changes in the environment. Of the many trends affecting the commercial marketing environment in the U.S. today, three provide parallels for the social marketer: 1) fragmented markets and media, 2) declining use of advertising, and 3) increased emphasis on intermediaries in the "selling chain."

1. Fragmented Markets and Media. The abundance of mature brands and proliferated product categories forced commercial marketers in the United States to develop sophisticated market segmentation strategies as early as the 1970s. As populations

continue to fragment and form splinter groups, marketers have begun to rely on data-based marketing (DBM) techniques made available to them through new computer technology. Social marketing programs, many of which are short on financial resources and confronting the same segmentation issues, are also likely to benefit from such techniques.

One result of this consumer fragmentation is a U.S. media environment that looks very different today than it did 20 years ago. Mass media, once effective and efficient in reaching mass audiences, is no longer the same tool in the 1990s. Network TV has lost almost one-third of its national audience. The arrival of the VCR, the specialization of magazines, and the growth of suburban newspapers and cable TV have permitted, as well as necessitated, a move away from traditional mass media as the primary communication vehicle for marketers. The challenge for the social marketer is to determine how to take advantage of these new media opportunities.

2. Declining Use of Advertising. The relative importance of advertising in the promotional mix has steadily declined as expenditures on other communication techniques have steadily increased. Sophisticated consumers, saturated with commercial messages, are now comparing prices and labels and looking for additional incentives to buy. Sales promotion techniques such as cents-off coupons, special prices, or two-for-one bonus packs are driving sales more than ever before. Public relations programs are reaching target audiences with an increasing variety of message formats for far less cost than national advertising campaigns. Advertising itself is including more nontraditional formats such as infomercials, video header inserts, and movie trailers. The sophisticated social marketers of the 1990s will not only recognize these trends but ask how they can optimize the cost efficiency, quick response capacity, and precision targeting of such communication alternatives.

3. Increased Emphasis on Intermediaries in the "Selling Chain." In the U.S., the balance of power is shifting away from the manufacturer as retailers gain control of sophisticated information systems. Consolidation of retail store chains and the introduction of electronic scanners has enabled the retailer to evaluate the profitability of every inch of shelf space in the store. As a result, they have begun demanding such things as "slotting allowances," cooperative advertising, and fees for setting up in-store displays. Today more commercial marketing dollars are spent against the "trade" than ever before. This trend is also occurring in social marketing as program managers are recognizing the increased importance of marketing to intermediaries such as media placement gatekeepers (PSA directors) as well as those in the service delivery system.

Marketing, as an ever-evolving discipline, will continue to change for commercial marketers as well as those attempting to market a social offering to target populations. Each of these changes in the commercial marketing approach of the 1990s signals an important trend for the social marketer. Below are some of the specific challenges social marketers face in the U.S. today.

- **Moving beyond awareness:** Many social marketing programs have built a solid base of awareness among major target populations. This was often accomplished using largely conventional media and commercial message formats. As programs focus on other issues (the maintenance of medical regimes, changed lifestyles, complex messages, the legal and regulatory environment) other tools and tactics have, or should have, become far more important.

- **Achieving the harder sell:** Mature social marketing programs are faced with the issue of diminishing returns as they struggle to address "hard to reach" audiences or hard-core resistors. It

may take ten times the resources to have an impact among these groups as compared to the more receptive and accessible segments of the population previously reached. It will certainly take very different strategies and tactics. Many of these approaches have been pioneered by commercial marketers in their efforts to reach narrow target markets. The media has already fragmented in order to accommodate splinter marketing. Social marketers may now borrow these techniques and capitalize on this fragmentation.

Ultimately, however, social marketers are faced with the difficult question of whether to continue efforts directed toward extremely difficult segments and lose much needed efficiency, or to change course and adopt some type of flanker strategy designed to meet the same long-term objective. For example, in order to reduce heart disease, a program might strengthen the focus on reducing cholesterol rather than continue committing major resources to combat high blood pressure among small but resistant target groups.

- **The diminished impact of PSAs:** Just as commercial marketers have found traditional 30-second ads to be less effective in today's marketing environment, social marketers are faced with the reality that the PSA format has a substantially diminished impact compared with 20 or even 5 years ago. Only 2 percent of all commercials on air today are 60 seconds or longer. The rest are 30, 15, or even 10-second spots creating an enormously cluttered media environment.

  Social marketers may want to consider paid advertising time in order to match their target audience's viewing patterns better as well as to increase their "share of voice." Nonconventional media formats may also provide greater efficiency and effectiveness for the social marketer. Certainly the expanded use of other communication tools and tactics such as video news

releases (VNRs) or satellite media tours should be considered.

- **Competing with mega campaigns:** A few social marketing efforts in the U.S. have marshalled sufficient resources to develop mega campaigns such as NIDA's "Just Say No" campaign. These highly visible media efforts have considerable fire power that is difficult for other social marketing projects to match. Smart social marketers will want to avoid being dwarfed by these efforts and concentrate their resources on communication tactics and media formats that don't directly compete for attention with these giants. Another alternative is to allow pro bono private sector consortia such as the Partnership for a Drug Free America to tackle the traditional media task, leaving the social marketer free to focus on less conventional tools and tactics.

- **Obtaining timely and useful information:** Today's marketing environment is so specialized and is changing so rapidly that timely and comprehensive planning information is more and more essential. Commercial marketers have led the way with huge interactive databases, many of which can be cross-referenced with one another. For example, it is now possible to add a few questions of interest (such as risk behaviors) to a huge ongoing study like DDB/Needham's lifestyle survey. In this way, the social marketer can profile those at risk on a multitude of other important dimensions: media habits, psychographics, mobility patterns, lifestyle activities, purchasing patterns, and much more. By tying together a number of databases such as VALS (Values and Lifestyles Survey), and IRI (Information Resources Inc.) with geodemographics such as PRISM or ACORN, a very rich set of relevant information can be obtained.

  To gain efficiency and precision, state-of-the-art social marketing programs will now look to these sources to speed up and

refine their information base. Massive, expensive, one-of-a-kind research projects are becoming less and less viable.

- **Forming partnerships:** As resources for social marketing efforts dwindle, it is important to pursue strategies and tactics that have a "multiplier effect." One approach is to link up with organizations that have financial or other resources to contribute in exchange for something of value to them. For example, commercial manufacturers of health-related products (e.g., contraceptives) might underwrite a consumer education program on the health topic (e.g., women reproductive health) in exchange for the awareness and credibility associated with such sponsorship. Health insurance companies might support HIV prevention programs as a means of possibly reducing future claim levels and for the positive PR associated with the gesture. A commercial marketer might conduct a joint promotion with a social product (a blister pack of CSM condoms and disposable razors) in order to reach a specific target group with product samples. While such efforts have been carried out by social marketing programs in the past, smart social marketers will seek to leverage every possible partnership in order to enhance project effectiveness in the difficult marketing environment of the 1990s.

In our efforts to tackle health and social issues through the technology of social marketing, it is important to recognize that, globally, we are in the midst of a major paradigm shift. Not only is the world changing but the way we view the world is shifting. Ultimately, this shift will be our most important ally. Today is not the time to hold tight to static models, be it a medical model, a social service model, or a marketing model. Rather, it is time to allow each discipline to follow its own natural evolution and to forge a new and appropriate technology to tackle the challenges facing social marketing in the 1990s and beyond.

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